Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Community Services and Supports Component
Stakeholder Input Process

Special Topic Workgroup: Cultural Competency
February 23, 2005

Workgroup Summary
For Discussion Only

I. Background and Introduction

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Mental Health Services Act (MHSA) has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the Act are designed to support one another leading to a transformed culturally competent mental health system. This concept is embodied in the Department of Mental Health's MHSA vision statement: "DMH intends to assure that county mental health departments expend funds made available through this Act to transform the current mental health system in California and move it from its present state toward a state-of-the-art culturally competent system."

On February 15, 2005, the Department of Mental Health (DMH) released a draft of the Program Plan Requirements for the Mental Health Services Act (MHSA) Community Services and Supports (CSS) component. Broad-based stakeholder input is critical for this document to reflect the goals of the MHSA in transforming the public mental health system beyond "business as usual."

The first special topic workgroup session of the DMH MHSA stakeholder input process on CSS was held on February 23, 2005 in Sacramento. A Client and Family Member Pre-Meeting, held from 9:30 – 11:30 a.m., provided an opportunity for clients and family members to discuss the workgroup session purpose, review the workgroup agenda, ask questions and provide feedback. Both the pre-meeting and the workgroup session were introduced with the same basic information and overview. The workgroup was held from 1:00 – 4:00 p.m. Thirty-five (35) individuals attended the Client and Family Members Pre-Meeting and 77 attended the workgroup session. In advance of the workgroup, the agenda for the session was posted on the DMH website with a paper titled, "Considerations for Embedding Cultural Competency." The paper was drafted by DMH as a technical assistance tool and was used to guide the discussions at the workgroup meeting.

II. Client and Family Member Pre-Meeting (9:30 – 11:30 a.m.)

Thirty-five (35) people attended the Client and Family Member Pre-Meeting. Simultaneous interpretation was available in American Sign Language (ASL), Spanish, Vietnamese, and Hmong.

A. Pre-Meeting Purpose

DMH staff described the purpose of the pre-meeting: to ensure that clients and family members (C/FM) attending the workgroup have the opportunity to contribute their knowledge effectively at the workgroup meeting. The pre-meeting is an opportunity for general orientation and information, not a time for specific, in-depth discussion of the topics. DMH staff and consultants reviewed the agenda for the meeting as well as a series of questions that would be discussed at the workgroup meeting.

B. Discussion of Stakeholder Input Process

Q: Where can we give written input?
A: There are three ways to provide input outside of these meetings:

1. Email mhsa@dmh.ca.gov. All emails go to the MHSA Team at the Department of Mental Health. The team will answer the questions in a timely manner.
2. Call the toll free number: 1-800-972-6472 (MHSA). MHSA team members will respond to calls within five working days.
3. Write to: ATTN: MHSA
   Carol Hood, Deputy Director
   Department of Mental Health
   1600 Ninth Street, Room 130
   Sacramento, CA 95814

Q: How will we receive notice from DMH when new information is available?
A: When a major document is issued, DMH will send an email to everyone of the participant list announcing the document (email blast). Review the website, www.dmh.ca.gov often for updates. For those stakeholders on the DMH MHSA mailing list who do not have an email address, hard copies of the information will be sent via U.S. mail.

Q: How do you find information on the website?
A: The MHSA Team is aware of the need to improve the website, making it more user friendly. You can expect to see regular improvements to make the site easier to access and navigate.

Q: Where can we find these resources mentioned in the cultural competency paper?
A: The resources that are mentioned will be posted on the website.

Q: Are you prepared to translate documents in other languages?
A: Yes. DMH is currently determining which documents to translate and into which languages. The DMH Vision and Guiding Principles document is being translated into 12 languages.

Q: Can you make sure PowerPoint documents are printable so that we can print them in time for the conference calls?
A: This issue is being corrected.

Q: Is it better to be downtown where parking is expensive and public transportation is available, or further out of town, where the parking is cheap and plentiful but public transportation is difficult to access?
A: We are trying to identify meeting locations with better public transportation access.

C/FM Comment: Try to set up carpools to bring people to meetings, using central locations to people pick up.

C. Description of the Process for the Small Group Discussions

At each workgroup, smaller group discussions will be organized to give participants the opportunity to provide specific, concrete ideas. The discussion in the small groups will be guided by a series of questions on a variety of topics.

Stakeholders were introduced to the questions that would be asked in each of the small groups. Any comments or need for clarification are listed following each of the questions. These questions are in addition to the questions identified on the February 23 agenda.

1. **What specific techniques can be used by counties to reach out to underserved linguistically isolated individuals and families, and racial and ethnic communities? Who in the community can help expand the reach? Who are the traditional and non-traditional partners?**

C/FM Comment: What about gay, lesbian, bisexual and transgender communities, and persons with physical disabilities? I'd like to see these two areas added.

C/FM Comment: There are other underserved communities in specific counties where the diverse communities that are not "of color" such as Serbians, Russians, etc. I'd like to see these groups added.

2. **What specific assistance or support is needed to gain the trust and retain clients from underserved communities in the system?**

C/FM Comment: When you are talking about cultural competency, the focus should not be on bringing our ideas of mental health to the underserved communities, but working within communities and expanding the to make it more meaningful to their lives, so that they will be more likely to seek services.

3. **What can you recommend to help the county hire and retain a culturally and linguistically competent workforce?**

C/FM Comment: I would like to discuss strategies to hire clients and family members of color to work in the system.

4. **What specific things can be done to expand the awareness, knowledge and skills of the current workforce to make them more culturally and linguistically competent?**

C/FM Comment: How do we define cultural competency? I do not like the definitions that I have seen.

DMH Response: The mental health system must have the skills necessary to provide appropriate services to meet the needs of individual clients. This means we must look at cross-cultural training issues, the disparities, social justice. How can disparities be eliminated in unserved communities? The definition needs to be broad and inclusive. We need to discuss whether the current definition is broad enough. The current definition will be brought forward at the meeting this afternoon.

5. **If you were designing your county's mental health system, what new programs or services would you propose to meet the mental health needs of underserved linguistically isolated individuals and families, racial and ethnic communities?**

C/FM Comment: Many of the recommendations in the paper are things we've talked about for years, for example, trust. It appears that services are money-driven: services are provided if they are paid for only. MHSA provides hope that there will be new model. Is there a process in which the DMH is thinking about changing the way they pay for services?

DMH Response: Most of DMH services are not funded through units of services, except for Healthy Families and Medi-Cal. Yes, this is an opportunity to promote the values of MHSA in influencing and reforming Medi-Cal, though that is a longer-term

effort. Many of the counties have developed strategies to provide these services within existing services.

C/FM Comment: A list of unserved and underserved groups was created at the pre-meeting. The groups listed include:

- Women/men
- Women with childcare needs
- Families
- People of color
- Minorities of national origin
- Immigrants
- Refugees
- Native tribes
- People with limited English proficiency
- Religious minorities
- People with a background in the justice system
- Gays, lesbians, bisexuals and transgender people
- People with bad prior experience with mental health system
- Veterans
- Rural or small counties
- Children and transitionally aged youth
- People in board and care homes and other institutions
- Elders
- Seniors with Alzheimer's or with physical/dementia dual diagnosis
- People with a dual diagnosis of substance abuse
- Inadequately served
- Victims of trauma
- Those with experience of homelessness
- Uninsured
- Physically disabled, including hearing
- People who cannot read
- People without access to technology
- People with transportation issues (those without cars)
- People who work during the day
- Families with more than 1 disabled member
- People who are unwilling to seek services due to stigma

DMH Response: While this is a very important list, it is very broad. The challenge is how to prioritize the underserved communities in each of the counties. DMH is not defining “underserved” but leaving it to the counties to define their own underserved populations for the purpose of cultural competency. The county cultural competency plans have tended to identify racial/ethnic/language groups for the purposes of cultural competency.

6. What specific strategies can counties implement to better monitor improvement in mental health disparities?

C/FM Comment: Does DMH have its own cultural competency plan and if so, where is it?
DMH Response: The counties are required to have a cultural competency plan. DMH has cultural competency plans for our state hospitals but not for headquarters. Also, we realize that there is need for a glossary.

C/FM Comment: Is this going to be a working document that can grow over time? Counties won't be able to address all of this in the short timeline.
DMH Response: This is a learning process and a developmental process that will continue to change.

C/FM Comment: For smaller counties, will DMH have a list for interpreter contractors that will help us?
DMH Response: California Health Interpreters Association (CHIA) has a list on the website www.chia.ws.

C/FM Comment: I see a big need for training. It seems that training is needed before the planning, especially for cultural and linguistic differences. We have the funding to do something different. We need funding to reach out to populations we have failed to reach because of language issues. For example, our population is 65% Hispanic and materials are not provided in Spanish. We need links on the DMH website to Spanish language information. We need Spanish radio programs and materials in Spanish.

C/FM Comment: What if everything on paper looks great, counties get the money and nothing is really done? Is there accountability?
DMH Response: Part of the accountability has to be at the local level, through an open planning process resulting in a visible community plan. Also, DMH has accepted the charge to address accountability.

C/FM Comment: Maybe the process can be similar to the Office of Civil Rights (OCR), or maybe DMH can develop a review process. We will all be able to monitor our counties because we will be involved in our county planning efforts.

C/FM Comment: Can DMH do anything about helping us when we are not heard as individuals? How do we make ourselves heard on a local level?
DMH Response: Find someone on a local level who will listen: County Mental Health staff, NAMI, client network. Build a coalition. If there are systemic problems, DMH can probably work with that county. If it is an individual person who feels s/he is not being heard, it is unrealistic to think DMH can intervene in each of these situations. The initial work needs to be done on the local level. If one path does not work, try to find another person who will listen. The county plan requires a 30-day local review period before a public hearing. People will have the opportunity to respond and say what they think is wrong at the public hearing. If it appears there is a problem, then DMH will work with that county.

C/FM Comment: When is the last day for feedback?
DMH Response: This is a work in progress. DMH will learn and continue to learn. DMH wants feedback about the cultural competence document by March 4, 2005.

III. Special Topic Workgroup: Cultural Competency (1:00 – 4:00 p.m.)

Seventy-seven (77) stakeholders participated in the Special Topic Workgroup session on Cultural Competency on February 23, 2005, from 1:00 – 4:00 p.m. The afternoon meeting included county and professional staff as well as clients, family members and advocates.

Carol Hood, DMH Deputy Director, and Rachel Guerrero, Chief of the Office of Multi-cultural Services, thanked everyone for coming and framed the discussion. The purpose of the special workgroup session is to focus on cultural competency early in the planning process. The anticipated outcomes of today's meeting are to better understand how to embed cultural competency principles in Community Services and Supports (CSS) and into the county planning efforts effectively.

A. MHSA Stakeholder Process

1. Process

Bobbie Wunsch, Pacific Health Consulting Group, facilitator of the MHSA stakeholder process, opened the meeting by reviewing the process for stakeholder input. This is the first workgroup in an extensive series of workgroup and general stakeholders meetings that will be held over the next year. There will also be conference calls in advance of workgroup sessions to review specific issues that will be discussed. People are encouraged to participate in both the conference calls and workgroup sessions in which they have expertise and interest. They do not need to attend every meeting but may follow the process on the DMH website.

There are five parts to all workgroup and stakeholder meetings:

1. DMH prepares materials for review at least two weeks in advance of each meeting
2. DMH sponsors a conference call on materials one week in advance of the meeting
3. Client/Family Member Pre-Meeting 9:30 – 11:30 a.m. before each workgroup and general stakeholder meeting
4. Special Topic Workgroup Session from 1:00 – 4:00 p.m.
5. Combined summary of both meetings will be posted on the web site within one week

2. Roles and Responsibilities of Participants

- DMH: The Department's role is to listen to what everyone has to say. Consistent senior DMH staff will be in attendance. DMH staff is available as a resource and as technical experts to provide interpretation of the MHSA and to respond to major issues raised.

- Facilitator: The Facilitator's role is to develop and manage the process for input by stakeholders at the meetings and to prepare summaries of all the meetings. The stakeholder process will vary, sometimes meeting in large groups and sometimes

dividing into smaller groups, to allow for more opportunities for participants to share their ideas, perspectives and expertise. The intention is to hear from everyone. There will never be enough time for everyone's feedback, so there will be additional ways to provide input.

- Stakeholders: The stakeholder participants' role is to participate in critical discussions and provide suggestions on the design of the MHSA. The stakeholder participants will review the advance materials and be prepared to share experiences, perspectives and expertise at the meetings or to submit individual questions and comments via the website.

3. Registration Guidelines

- Register on the website for any workgroup sessions you plan to attend. For those without access to the web, tell the people at the registration desk which meetings you plan to attend. Registration ensures the booking of the appropriate size space.
- There is no fee to participate.
- Counties and agencies are requested to send only one person per workgroup session. Client and family organizations are encouraged to use their best judgment in the number of attendees that they send.
- Workgroups will be organized sequentially with topics and focused questions for discussion, each building on one another. It is important to come prepared for discussion topics at each session, posted on the website. You do not have to come to every workgroup; come where you have expertise and special interest.
- Listening is a critical component to the process, even when you do not like what the other participants are saying. Be open and willing to explore new options and ideas. It is important to recognize that not everyone will be happy with everything that comes out of the sessions. The best way to achieve the goal of improving the system is for everyone to commit to listening to each other, regardless of different opinions.
- Do your best to stay focused on the issue at hand for the day. There may be a time in the meeting when you are asked to hold your comment until later.
- Simultaneous translation is available at this first workgroup meeting in American Sign Language (ASL), Hmong, Spanish and Vietnamese. Please let us know if you know people who would come if they knew these services are available. People may be asked to request language interpretation services at the time of registration in the future.

4. Questions and Comments about the Process from Participants

Q: Are scholarships for transportation and hotels possible for those who cannot afford it?
DMH Response: For general stakeholder meetings, DMH is providing funding for three people from each of the statewide consumer and family organizations: NAMI, UACC, Client Network. For each applicable workgroup, DMH is providing funding for two

people from those same organizations. It is legitimate use of county planning funds to send additional clients and family members to these meetings.

Q: Will DMH fund participation for local coalitions?
DMH Response: No.

Comment: If you limit people by not allowing funding for people who cannot afford to attend, you are excluding many people. Then it is just business as usual. Counties are going to do the same thing. DMH should rethink this.

Comment: The counties have the planning money to send as many consumers and families members as they want. Los Angeles is likely to be very committed to adding people.

Comment: Transportation is such a big issue. I would like to see DMH take leadership for the counties. For example, to provide taxi vouchers.

Comment: Use the paratransit system to arrange transportation.

Comment: I think is a mistake to choose this location and recommend that we change it to a place that is more centrally located and easily accessible to public transportation.

Comment: I am really concerned that we have not provided for the Native American tribes, as we have for county representatives.

Q: The website was hard to navigate. I could not register for today and I could not locate the resources.
DMH Response: The way to locate resources on the website is to find the “resources” link. The MHSA Team is working on improving the website. Please recommend other documents that can be used as resources. We need resources relevant for specific communities.

Q: This is the first time I have seen DMH come up with as comprehensive a list as this in terms of operationalizing cultural competency – thank you. I understand that this is a process. At what point will there be an end? At what point will this document have teeth? When will it be a requirement not just a recommendation that it must be embedded into the plan?
DMH Response: Two documents are involved. This one is technical assistance for counties as they reach further in their efforts to embed cultural competency in their planning. The MHSA requirements are in the CSS draft document, where approximately half the money will go. The intention was to embed the minimum cultural competency requirements into the CSS component. Cultural competency will be woven throughout the age groups. The CSS requirements for counties will be finalized by May 1.

Comment: I am concerned who at the county level is going to define underserved populations. Underserved should be as identified by a community needs assessment. It requires the county to be responsive to the community.

Comment: I hope that once the funding is in place, there will be money for communities to go out and talk to people.

Comment: If you want to truly embed cultural competency, you have to transform the whole system. We are trying to graft this great new cultural competency system on a system that is not ready to receive it.

5. Small Group Discussions

The workgroup divided into three sections to discuss the technical assistance document:

Group 1	Considerations for Embedding Cultural Competency in County Plans
Group 2	Considerations for Culturally Competent Client, Family Member and Community Engagement in Counties
Group 3	Considerations for Culturally Competent System Transformation

Each of the small groups discussed the questions identified on the agenda as well as a more specific list of similar questions. The summary of what happened *across the small group discussions is summarized here for the similar questions*. For the questions on the agenda, the small group discussion is also provided, identifying the agenda question number and the specific small group.

MHSA Definition of Cultural Competency – The definition of cultural competency was circulated in the small group discussions.

- Cultural competency: cultural competency is a set of congruent behaviors, attitudes and policies that come together in a system, agency and among professionals that enables that system, agency or those professionals to work effectively in cross-cultural situations. (Cross, Bazron, Dennis and Isaac. Toward a Culturally Competent System of Care, Volume 1. 1998.)

  Cultural competency includes language competence and views cultural and language competent programs and services as methods for elimination of racial and ethnic mental health disparities. There is a clear focus on improved quality and effectiveness of services. Culturally competent programs and services are viewed as a way to enhance the ability of the whole system to incorporate the languages and cultures of its clients into the service that provides the most effective outcomes and creates cost-effective programs.

Identification, development, promulgation and adoption of culturally competent best practices for care must be an integral part of ongoing culturally competent planning and implementation of the MHSA.

1. Please comment on the definition of cultural competency circulated today.

- The Planning Council developed a Master Plan for DMH in 2003 and a definition of cultural competency which was short and simple: *cultural competency has been described generally as the ability to appreciate and recognize culturally different people and get along with people different from oneself*
- The Planning Council's definition is elegant, but if you leave it as is, you miss eliminating disparities and working effectively by using outcomes. The definition does not force looking at eliminating disparities
- Add quality of community
- Include lifestyle and extended family
- Define race and ethnicity
- Include people with physical disabilities
- Specify cultural identity variables: race, ethnicity, religion, language, socio-economic status, sexual orientation
- Simplify, do not use so many words
- Two groups that should be included in any discussion of cultural competency are gays, lesbians, bisexuals and transgender people and those facing physical challenges
- I like the comprehensiveness of the definition. But the county should be asked to specifically describe exactly who their underserved population is

Questions from the Agenda

1.1 What are the most critical issues related to cultural competence that county mental health programs should include in their planning processes?
(Embedding Cultural Competency Small Group)

- Set up reimbursement structures to provide additional money to providers who can work with linguistically isolated individuals and families, and racial and ethnic communities
- Reimburse services in group settings
- Work outside traditional units of service. There is a lot of innovation going on outside the reimbursement model in the private sector
- Develop a training component to help county planners learn how to reach out to those who are not being reached
    - Cultural competence at different levels of organizations with specific training on sensitivity, awareness and skills to work with underserved communities
    - Training on how to facilitate focus groups
    - Training to link with communities that do not trust the community mental health system

    - Training mental health systems staff to work as a team to benefit the clients, be supportive of each other and partner agencies
    - Make available different levels of training for administration, staff, and community members
    - Learn about models of mental health services that are working in other countries that will enhance the thinking
- Assess self-help and consumer driven programs to see if they accessible to the wide range of communities. Solano County's self-help group for Latino families is working well. We went to a Catholic church in Vacaville and asked the community what they needed and then created it
- Think through what is native to the communities. Work with communities that have not been served. The notion of a needs assessment is critical. It requires thinking in new ways
- Do not make the solution very complex: nothing about us without us

1.3 How can we measure that a county has done an effective job in embedding cultural and language competence in their MHSA planning? What specific strategies can counties implement to better monitor improvement in mental health disparities? *(Embedding Cultural Competency Small Group)*

Possible Measurement Sources/Opportunities

- The federal government requires Performance Improvement Projects. The PIP projects could be defined specific to cultural competence and used effectively rather than simply as an exercise
- Use the system already in place, i.e., human resources: look at the percentage of ethnic minorities; create a baseline and then set a goal to increase
- Build cultural competence measures into Quality Improvement (QI) work plans that builds a "how" that actually has teeth, or use the cultural competence plan
- Have a baseline of current clients and have a mechanism that gets feedback from clients (focus groups, surveys, etc)
- Go to Sacramento to the Chinese Culture Connection (CCC), Southeast Asian: they held a cultural competence discussion, not necessarily with clients/families, but of the system
- Hire clients, family members, etc. To serve clients/family groups you need to look at cultural competence of the whole system
- MHSA stakeholder survey: who participates, how many clients and family members. It should be started now and be included as part of the planning process

Priority Focus

- The county agency needs to know cultural competence is a priority
- It needs to start from the top and DMH should adopt cultural competence. Not just give us lip service
- Embedding cultural competence starts with the leadership of an organization. Cultural competency must be a topic at every meeting and used as a lens for decisions. Make sure that persons responsible for this do not burn out

- DMH could model the accountability
- Counties should use the cultural competency plan they have already developed
- Need community-specific advocacy
- There is a lack of trust that the system will change, from clients to providers. We have discussed many of these issues for many years and where are we going with it? How much impact will that be when we are talking about 15% of the budget?
- Need numbers/teeth – some way to count the results

2.1 What can county mental health programs do to effectively include underserved clients and their families in their planning processes? What is missing from the attached technical assistance document? *(Clients and Family Members Small Group)*

Incentives

- Remove barriers
- Offer scholarships for training for consumers
- Provide stipends to participate in meetings
- Provide transportation funds
- Pay for taxi fares
- Pay for lodging and meals
- Provide exchange vouchers in lieu of cash or payment such as grocery vouchers
- Even if you provide large amounts of funds for programs, we will not use it: many from underserved communities are not used to seeking or asking for help. This implies a need for education, to help people know their rights, and what services are available
- Help with computer access
- Reimburse for long distance calls for organizing

Meeting, Locations and Promotion

- Meeting places must be at bus stops: we need better public transportation access to meeting locations
- Open up more community centers and places people can gather
- Have planning meetings in environments where people gather (churches, neighborhood centers, etc.)
- Open a media center for communicating to public at different levels of literacy; e.g., radio for outreach for those who cannot read; posters in other languages, Hispanic TV ads, etc.
- Fund consumer survey expenses
- Use culturally appropriate formats for meeting
- Listen to what people have to say and make sure they know you are listening
- People need to feel a connection or they will not stay

- Some are reluctant to come, unless advertising specifies that services are for minorities: past experience is that advertising is Anglo-based
- We need time in meetings to process input and question the issues

Other
- We do not trust the system or government operations; outreach has to be from within the community; sensitivity to the cultures is very important
- Try to hire specifically people of color
- Immigrants want to bring loved ones but are afraid to lose the right to bring family over if we use Medi-Cal or other government-funded programs
- Website: please provide the identity of who sponsors articles

2.2 What additional recommendations can be made to increase the participation of underserved racial, ethnic, cultural and limited English speaking clients/families in local planning processes? *(Clients and Family Members Small Group)*

- Use libraries as a central/neutral location
- Once youth are adopted from foster care, they do not know what support is still available
- Promote through newspapers, radio, flyers, media, Hispanic TV
- When meeting announcements are to be made, indicate that interpreters will be available
- Post-adoptive transitional age youth need a link to call and resources to keep in touch with the system, through African American English (AAE) funding

3.1 What are the components of "system transformation" related to cultural competence that need to be included in county mental health planning efforts? *(System Transformation Small Group)*

Staffing Issues
- Provide higher pay for bilingual or multi-lingual staff who must be certified
- Monolingual clients need to have providers who speak their language
- Need for adequate bilingual providers
- Train providers to work with interpreters
- Recruitment and training of culturally competent workforce
- Hire clients to work with their communities to reduce stigma
- Tie data to target populations and fiscal impact; do not take away culturally competent staff who address issues
- Require providers to be patient friendly

Specific Concerns and Steps
- Destigmatization at all levels
- Add ethnicity by age to CSS chart

- Include Native tribes in county plans
- Provide education with co-providers of service: emergency room physicians, law enforcement, businesses, schools
- Develop service plans for what client wants, not what provider wants client to do
- Decentralize control and power to the grassroots level
- Reduce costly involuntary commitments
- Add more crisis residential and peer run programs

Promote Cultural Competency

- DMH should provide more direction and leadership
- DMH must incorporate cultural competency or nothing will change – there needs to be a change of attitude
- Culture and lifestyle must be included in all discussions
- Show link between improving cultural competency and reducing disparities
- Cultural competence is so vast that there is no county that can get its arms around it

Philosophical Steps/Concerns

- Think differently
- Transformation is a long term process
- Change attitude, beliefs, values, types of services provided
- Change perception of what you were taught and what is the reality of the consumer
- Need to balance the tension between efficiency and cost savings on the one hand and effectiveness and responsiveness to the client on the other
- It should be as easy to go to a mental health provider as to a medical provider
- Be flexible and adaptable
- Cultural awareness of homeless and dual diagnosis

3.2 What roles do adapting or adopting Evidence Based Practices (EBP), promising practices or emerging practices play in planning MHSA for multicultural populations in the state? *(System Transformation Small Group)*

- Evidence-based practice (EBP) does not include cultural competence issues. Find out what is working in communities and document it
- We need resources to document community practices to build EBP
- Guard against over-emphasizing EBP
- EBP might hamper innovation
- EBP is okay in clinical setting, not in peer programs or leadership
- EBP can provide good directions but might not be the road to take
- No relevant culturally competent research
- Must rely on EBP that is tailored to U.S. experience: how can we help refugees and new immigrants?

2. What specific techniques can be used by counties to reach out to underserved communities, linguistically isolated individuals and families, and racial and

ethnic communities?

Get to Know Underserved Communities

- Know how to go to and become part of the communities
- Use the local resources and ask people what they need
- Once you have successful outreach, how do you get the people you have reached to tell you what they really need? What if they don't even know what they can request? How do I put the ideas out there without planting ideas in their head?
- We often identify people from underserved communities who can participate in planning, cultural competence committees, etc. but they often stop coming after one or two meetings. We need to provide assistance to keep people engaged and supported as they do the work
- Ask the community or the specific underserved group what they need to be able to attend and what the challenges are preventing their participation. Be willing to be creative in problem solving and make personal commitments to individuals as needed. For example, I did outreach to young people. When I asked why the girls weren't coming, I learned parents did not want their daughters on public transportation with boys. I made a personal commitment to the girls' parents that I would transport their daughters to and from meetings
- Be culturally sensitive to the structure of the forums
    - Have multi-generational grouping which we typically resist
    - Pay attention to food/culture, for example, Chinese people do not consider sandwiches as food; a participant from India at a meeting could not eat as there were no vegetarian food offerings
- Pay attention to location: many people, especially homeless people, will not go to a meeting in a county building, or close to a jail
- Seeking mental health services is culturally difficult for Latinos; it is not a normal means of getting help in their culture

Trust

- Trust is an issue, especially with linguistically isolated people. You want bilingual/bicultural staff, and if not, interpreters who are trained to interpret, rather than just native speakers
- My county serves one pocket of Latinos but ignores others, and yet it says it has met the need
- Many in the Latino community are afraid to make contact due to legal status: the outreach worker may have great rapport but cannot establish the trust
- Program funding should consider creating enough paid time for the same worker to outreach to the same clients. Too often different people are sent out and when potential clients see different faces they lose trust, or might be denied care because they cannot reach their assigned worker
- Clients are still concerned that the system is being controlled by Medi-Cal. I was hoping that changes would come about because there are enough reports saying the system is broken
- Undocumented immigrants may want help but are afraid, especially with changing providers

- Need a developmental model of outreach to gain trust
- Most Latinos are low-income but are working and need to have community education or outreach after regular business hours; such a show of accommodation could be a beginning of gaining trust
- Use positive terminology, mental health vs. mental illness, in order to invite people in and create a climate of trust

Specific Techniques/Programs

- Wraparound: we were working with migrants with many needs. We contacted the Mexican consulate to hear what kinds of services they were not getting. We tracked this and then we met with the consulate again and asked if we could take names and describe what services were available that they were asking for, with the Consul there. The people who came to this initial meeting became the leaders. We were able to provide one of the services they wanted and then were able to make referrals. There was a Latino foster parent group we were able to work with
- Use a system like minor-consent Medi-Cal: let teens know there are ways to deal with problems without family getting involved
- Have repeated communications to communities
- Use Public Service Announcements (PSA) in appropriate languages
- Use cable channels
- Use ethnic newspapers and channels
- Create a user-friendly poster, an educational piece which addresses strategies for outreach
- Conduct de-stigmatization campaigns with visual aids
- Must hire ethnic people into the system
- Latino service providers in Sonoma County have a “how-to model” (website); both for non-profit agencies and for-profit business community (through the Spanish Chamber of Commerce)
- Confidentiality is especially challenging but important in small counties where everyone knows everyone else: (1) Stigma is a general public concern; (2) They set up a confidential system so that clients using the system cannot be noticed by the rest of the community
- Link community meetings and outreach to holiday celebrations
- Include other family members in assessment
- Communication between Western and Eastern practitioners (alternative healers), monks, temples, curanderas, clan leaders
- Use natural healing, food and practices
- Cultural competency plans should be inclusive and adaptive to specific communities
- We are all individuals – we need specific outreach, not one size fits all

Places to Go

- Think outside the box, because underserved individuals will not come without encouragement. Go to different churches in a range of denominations, business community, health fairs, migrant camps, align with other agencies which do not

usually partner with us, dental groups, community based medical centers, school-based organizations, parenting groups, other existing support groups
- Go where people gather
- Reach out to faith-based or social groups
- Link and collaborate more with primary care and psychiatry
- Talk to mental health directors in community centers

Specific Communities
- Children who are making progress and then age-out to adult system, then often decompensate as a result of the change in services
- Outreach to and communicate with younger youth (elementary age) through music and videos
- AB 2034 program serves unsheltered people by formerly homeless clients; its motto is “persistent, patient, non-threatening”
- Reach out to developmentally disabled groups and family groups
- Reach out to AOD groups
- Reach out to the HIV community
- For gay, lesbian, bisexual and transgender outreach, use existing resources, marketed as a safe place

Barriers and Challenges
- We are afraid that when we advertise we will not be able to meet the need
- We have an issue as a small county, having to involve a staff member more than 50% in the planning process; staff are culturally and linguistically diverse, but we are restricted from using these staff because the county is so financially strapped and they are spread too thin. We should be able to use our assets without 50% restrictions and other parameters/restrictions with a provision to compensate workers for their time
- Denial of service due to immigration status
- Need to go to county boards to get help in addressing stigma and discrimination issues. Tuolumne County is 99% white and has seen much violence in relation to race crimes, resulting in mental health issues, stress, depression

3. Who in the community can help expand outreach? Who are the traditional and non-traditional partners?

Collaboration
- Build on what has already been done; some agencies (e.g., First 5, Healthy Families; other healthcare, and healthcare enrollment) have already dealt with issues of trust; work with partners that have knowledge to share
- DMH should provide incentives to counties for collaborative work across systems
- School and community can expand outreach with bilingual staff who can get out into the community
- Groups with money need to help: DMH, hospitals, schools, state, county

Work with Community Leaders

- Meet with professional and natural community leaders
- Collaborate with community leaders, churches, faith-based organizations
- Most critical point in outreach is first reach – once engaged, then you develop leadership
- Leadership training for consumers

Work with Peers

- Counties need to develop more self-help and peer driven groups. Counties cannot meet all the needs that self-help groups can help with
- Offer peer support to individuals
- Work with peer/consumer providers to provide peer support and knowledge; provide consumers for opportunities to work

4. What specific assistance or support is needed to gain the trust and retain clients from underserved communities in the system?

- Ally with local leaders which builds trust
- Hire consumers as providers; offer responsibility to build self-esteem
- Use trained interpreters
- Hire community people into meaningful jobs
- Allocate money to support community leadership
- Identify weaknesses and identify strengths in community
- Develop policies to promote family preservation
- Provide incentives that assure children will be safe
- Provide incentives to families to participate in meetings: using food, transportation, childcare, money for family activities, store vouchers, groceries, gift cards to Target
- Clients may come from a government they do not trust, so they are worried and fearful. Forms at intake scare people off. We must gain their trust before they have to fill out forms; bend the rules a little until they feel safe
- What about early intervention in the schools? Kids do not feel they have a voice; they cannot recognize mental illnesses; some come from other countries and fear family deportation; some do not know where to go for help; others fear their family being pulled apart; and others fear they will damage family pride if they reach out
- Go out into community settings, like churches and temples, and conduct educational sessions in multiple languages
- Use non-stigmatizing language
- Use International Day as an opportunity to display and teach about cultures
- DMH needs to demonstrate commitment to Native Americans: there is no funding or mention as a government entity. Ask the tribes to come to the table
- Most important in Latino community: If we meet in government buildings, no one goes; therefore, choose churches, other community places

- Bring in Stamp-Out-Stigma for specific cultures that includes everything in cultural competence

5. What can you recommend to help the county hire and retain a culturally and linguistically competent workforce?

Recruitment Strategies

- Go to the community and identify people you want to hire and train, working with colleges and community-based organizations
- Hire transitional age youth to bring in other transitional age youth
- Target bilingual children who interpret for their parents to become staff interpreters
- Partner with educational institutions and community-based organizations who may be willing to help with the education process; for example, CSUS has a masters program in collaboration with community-based organizations
- Count contractors and clinics who can train and retain bilingual/bicultural providers as part of the CMHS staff

Recruitment and Retention of Clients and Family Members

- *Building Employment Services Team* (BEST) is a model program that helps clients seeking employment: for clients to go to work without endangering their health and other benefits, they need benefits-counselor specialists
- Interlink Self-Help Agency provides a setting where people come in order to get better – working "up" best steps to self-empowerment and employment
- Volunteer Center of Sonoma County provides volunteer work as a first step to employment: it gives exposure and can hone skills without a complete commitment and gets people used to working
- Create a stipend to help people earn their degrees and come back and work
- Develop a support system for consumer providers
- Clients should do internship/job-sharing so they do not go into relapse
- Use job-sharing so they meet at peer level
- Some consumers need a graduated structure and support to maintain their job: offer a career ladder and part-time hours
- Be very careful not to stipulate full-time people: unprepared consumers with too many hours are likely to fail
- There are people who want, need and can handle full-time jobs: do not exclude this opportunity, but monitor each individual
- People want to get out and work, but cannot get a job because of our culture: we should be united as one to fight this
- Some of our consumer/staff advise administrators on hiring of other consumers. In order to maintain that role, we need specific job descriptions

Work Environment

- Create an environment that is welcoming and engaging for and orient and mentor culturally diverse staff

- Change the attitude from new and old staff (“us” vs. “them”)to we are all trying to serve the community
- Remember we are a team and must be client centered: have empathy for the client, gain their trust, and remember “He's *our* client, not *my* client.” If a client is sent away while waiting for primary case manager, s/he could go into crisis. Our motto should be, “Together we can do it”
- Need to solve the county mental health services culture
- Establish a ranking system to protect most recently hired bilingual/bicultural staff in cost-cutting times
- Need to retain good people and not be forced to retain bad workers

DMH Support and Assistance

- Mandate that in order to be a contractor for MHSA, counties must employ a client or family member
- Mandate that there is someone at all times who can interpret/translate for clients
- DMH could provide templates for job descriptions

6. What specific things can be done to expand the awareness, knowledge and skills of the current workforce to make the workforce more culturally and linguistically competent?

- More clients in the workplace
- Have staff who are clients
- Hire clerks from underserved communities who become the “welcoming committee”
- Create the culture so that the staff is flexible in terms of work loads, including part-time schedules so they can attend school
- Use Evidence-Based Practice (EBP) for supervision so that we supervise to a model
- There should be more staff who are knowledgeable about diverse community cultures
- Think holistically, not just about clients’ depression, but about what else may be going on
- DMH should sponsor trainings with practical applications
- Staff have awareness of cultural competence issues, but are less sensitive and their skills are even lower: we need practical applications to change the way we do business
- There has to be a way for the system to metamorphose into a caring gentle workforce. We need better thinking. Everyone is afraid

6. Large Group Reconvene

The small discussion groups ended and participants returned to the large workgroup meeting to wrap up the discussions.

In ten years, how will we know if we have achieved a culturally competent mental health system?

Ideal System

- Mental illness will not have the stigma, it will be like a medical ailment
- The system will show these cultural competence plans are already integrated
- We will not need specialized cultural competence planning because it will be integrated
- There will be a network of well-funded self-help groups, crisis residential programs instead of hospitalization. Involuntary commitment will be very rare
- Family, clients and providers are working together
- Our meetings will all look like this meeting today
- Like one stop job centers, we will have one stop wellness centers, with services and housing. The community works together and we will be doing prevention
- If at one point I say I am competent, it is a problem. When I can say I am not competent, I need to keep my heart and mind open. This is about humanity and respect
- There will be a vaccine so that mental illness will be completely gone and our kids and grandkids do not have to go through it
- Take it away from the pharmaceutical industry and take it back to nature
- This is the time to be united – united we stand and divided we fall

Access

- There will be enough doctors to serve whatever ailment you have
- It's about access and de-bureaucratizing the system. We will want to know how we can serve clients better, not whether. Much more needs based: not are you sick enough, poor enough or have you filled out the right forms?
- A person wakes up noticing symptoms, goes to their community clinic and is seen by a physician who treats physical illness and right next door will be a mental health provider
- No money barriers, no language barriers
- There will be no disparities in services
- If you need assistance in this area, you will know where to go and what is available, there will be respite care. There will be an opportunity so that people do not need to hide. Stigma would be gone
- Any family member could be served without the family being disrupted

Staffing

- All staff will be culturally competent
- You can go into a clinic and you will not need an interpreter
- More than 1% of staff is bilingual/bicultural
- Clients and family members are hired readily
- More people will be working in mental health at all levels and all will be culturally aware, sensitive and trained. More money will be allocated to training and education

The meeting ended at 4:00 p.m. with a reminder of upcoming conference calls and workgroup meetings.

All participants were asked to complete an evaluation form.